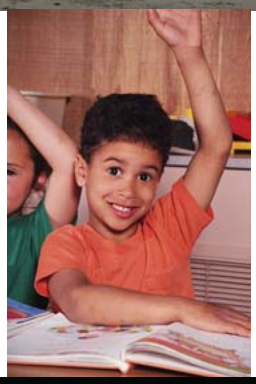

III. BRINGING IT ALL TOGETHER

A. Seven Overarching Themes

B. Findings and Observations

C. Consideration of Options

III. BRINGING IT ALL TOGETHER

The Task Force deliberations over the 5-month period of October 2002 through January 2003, proved to be an invaluable process of sharing data, making queries, analyzing the information presented, exploring options and considering the strengths and weaknesses of their application to the community. Throughout the process and upon presentation of the individual committees' final reports in January 2003, the Task Force's Executive Committee began to come together and started to build consensus on 7 emerging themes.

A. Seven Overarching Themes

1. **Reduce the Growing Ranks of Uninsured**
   Address the lack of health insurance coverage to the uninsured through initiatives such as the expansion of the Medicaid Program, development of the Health Flex Program for the working uninsured, and expansion of school based health programs.

2. **Promotion of Wellness**
   Assure primary focus on preventative care, primary care and mental health service provision and coverage.

3. **Assurance of Accountability**
   Make provisions for both Consumer and Provider Advisory Groups; granting of authority to collect and monitor the efficient use of County health care funds.

4. **Revenue Maximization**
   Address the need to devote attention to acquire appropriate levels of federal and state dollars while maximizing local resources through the effective leveraging of healthcare funds.

5. **Building on Existing Programs and Resources**
   Propose greater community outreach and education to increase enrollment in existing programs, such as the Medicaid and the KidCare Programs.

6. **Promotion of Community Collaboration**
   Promote greater collaboration among elected officials, healthcare providers, health planning organizations, the business community and consumer groups.

7. **Eliminate Conflicts of Interest**
   Separate health governance, funding and monitoring from direct service delivery.

B. Findings and Observations

A special Planning Retreat of the full Executive Committee was conducted on March 4, 2003 to forge a consensus document of findings and conclusions of the Mayor's Healthcare Access Task Force.

Their findings and observations are as follows:

Populations in Need

- The number of uninsured residents in Miami-Dade is 450,000, nearly one-quarter of the county's population.

- The number of persons with mental illnesses is on the rise. Miami-Dade has a population with mental health needs 3 times greater than other major metropolitan area of this size.

- The non-working population lacks access to primary care. Development of a low-cost plan would be cost-effective and beneficial to the community.

Health System Coordination and Integration of Services

- The system lacks integration of mental health and substance abuse with other health programs. Yet, the number two diagnosis across the country is depression.

  Illustration: Psychoses is one of the leading DRGs for both all patients (3^{rd}) and charity care patients (6^{th}) in Miami-Dade among hospital discharges.

- There is a lack of coordinated community outreach being integrated across all providers and health advocacy community groups, and there is no countywide inventory of outreach and education programs/activities.

  Illustrations: Prenatal patients can be given access to Medicaid coverage under the presumptive eligibility provisions. This would provide access to care early in the course of pregnancy. Women can also be identified for Healthy Start Services through a Prenatal Screen. Hospital settings could be utilized to identify individuals who may qualify for these programs.

- Presentation in Emergency Rooms is not a stand alone event; there needs to be a community-wide process in service delivery.

- There are gaps in services, both in the continuum of care provided (from primary care to tertiary care) and on a geographic basis (specifically West Miami-Dade County).

- Only 20 schools have established health programs that are appropriate to the students' needs. Moreover, 60% of all students are potentially eligible for Medicaid but are not enrolled. All of the children registered in schools are not screened for Medicaid eligibility. Immigrant children (enrolled in schools) who would not qualify for public assistance programs due to their status have not been fully taken into account. For them, a school based program may be their only source of healthcare.

- There is limited coordination of health education, promotion and disease management in public schools.

- Approximately two-thirds of all Miami-Dade physicians accept Medicaid patients; however, many Medicaid recipients do not feel they have access to basic health screening and medical diagnostic tests such as mammography and colonoscopy.

Community Coordination and Accountability to the Public

- The current system lacks adequate flexibility and responsiveness through its existing structure.

  Illustration: The PHT has limited mechanisms for consumer input. It has been recognized that recent efforts have been made by the PHT to build greater participation through posting minutes on the internet and broadcasting future board meetings. However, there is no public forum for discussion of county-wide health system issues.

- The health care system lacks a community consensus building process. There is no 'organizing platform' for community involvement; no coordinating body on community health issues and no singular, unified voice for county-wide integration of health services.

- The Task Force has determined that based on previous studies reviewed and their own deliberations that a conflict of interest exists between the allocation of funds and the management and provision of County funded health services and programs.

- There is a lack of transparency and accountability to the public. The Board of County Commissioners (BOCC) needs to make the PHT fully responsible in reporting its performance. Reciprocal accountability is key. There needs to be a shared vision and mission on how to deliver health care.

- The community needs to effectuate better coordination among providers. There is tension between providers when funding and service delivery is under one umbrella.

- There is a problem with adequate representation and balance on Public Health Trust Board. There is a lack of meaningful input on county-wide health issues.

- While a commitment to quality exists, there is the lack of an ongoing monitoring and evaluation to certify that quality.

- There is difficulty in accessing information. There is a need for accountability and transparency of public funds. A simple request by the county for an audit would not address the issue; the community needs an ongoing process.

Financing of Health Programs and Initiatives

- Miami-Dade County does not take full advantage of the available federal and state funding to improve access to health services. Florida is a donor state and yet Miami-Dade County fails to acquire its proportionate share of dollars for financing health care services.

  Illustration: At a recent meeting with hospital Chief Executive Officers and another meeting with Ruben King Shaw, the Task Force identified 4 programs that the local community is not tapping into to enhance services. Additional research by members revealed that considerable funding opportunities were not being pursued by the local community.

- It is possible to attract additional funds when providers work together cooperatively.

  Illustration: Two hospitals were recently funded by the Federal government to develop a diabetes disease management program and a primary care initiative.

- There is no coordinating body to provide leverage on the state and federal levels to improve access to health care dollars.

  Illustration: A matching grant under the Robert Wood Foundation was not awarded for a Sickle Cell Anemia project because at least 3 applications had already been received from Miami-Dade organizations. The Foundation cited the lack of community coordination and partnerships as the key reasons for non-approval.

- Any new program that the County supports should not permit Florida to be remiss in maintaining their efforts to fund programs such as the KidCare Program. The Federal government should also be held accountable for providing support and health services to immigrant populations.

- The health insurance and coverage plans researched show that utilizing a shared cost approach based on a one-third approach each among employees, employers and public resources, would supercede any existing discounts.

- Previous program experience from other communities suggests that it is best to experiment with the small business market. It is important to work closely with the local chamber of commerce and identify their role.

- Introduction of the proposed Health Flex Plan would need legislature language for UPL for July 1, 2003 implementation.

- When creating a health plan, a health system needs to identify its core business. There is an inherent conflict between health care delivery and a health care coverage option. A party should not negotiate with itself. In addition, the entity would be driven by two competing interests: keeping the patient in the hospital to collect insurance reimbursement (health care provider) versus keeping the patient out of the high cost setting (insurer).

Information Technology and Data Sharing

- Information technology is not integrated among all providers. For example, appointment setting, eligibility determinations, and patient medical records, are not universally available across clinical settings. As a result, the necessary follow up care is not integrated among primary care, specialty care and other points of service. HIPPA regulations may, however, impose restrictions for patient consents and other forms of documentation to protect patient confidentiality. An entity charged with operation of such a system, may prefer to initiate a small pilot in order to develop the appropriate procedures.

- There is a need to determine efficiencies across the full system to avoid duplication and utilize limited dollars more efficiently. Also needed is a standard definition of charity care for making intelligent and coordinated decisions.

C. Consideration of Options

Thanks to extraordinary work of dozens of community leaders, and the vision and courage of the County Mayor, the Task Force has developed an number of options for expansion of health care access and coverage for the uninsured in Miami-Dade. While addressing the needs of the uninsured was its primary task, other related and critical topics have been explored that address access and quality of health care for all residents of Miami Dade. Due to time, staff and funding constraints, not all of the options for health care coverage have received the same level of analysis and attention.

Once the process of assuring coordination and innovation is given to an authorized body, that group will be equipped and empowered to assure that the best possible choices for the community are considered and implemented.

Alternative Health Coverage Options

National and state policy experts were consulted in outlining these options, including representatives of the Center for Budget and Policy Priorities, Community Catalyst, the Access Project, and Families USA. At a national conference on health access held in

Washington D.C. January 23-25, 2003, issues of Medicaid Buy-In were raised along with other coverage options when speaking with legislators and their policy advisors from around the country. These discussions were invaluable in presenting the options below.

The five options are summarized as follows.

#1—Flex Plan
This proposal was prepared by the Coverage for the Working Uninsured Committee. It provides a no frills "flex" benefits package authorized by Florida Statutes for demonstration purposes. Costs would be shared by employers, employees and government (1/3 contribution from each). Eligibility would be limited to those earning under a set % of the FPL (e.g. 200%) for employers that have not provided coverage for a set time period (e.g. one year).

#2—TrustCare
The Public Health Trust (PHT) created a pilot using its own funds to provide a benefits package to 1500 uninsured residents of deep South Miami Dade earning up to 150% FPL. It provides a Medicaid "look alike" benefits package with certain exceptions such as a generic prescription benefit. Only a limited set of providers is included. PHT representatives report that the pilot has been successful and will likely be expanded.

#3—Non-Catastrophic Coverage
This proposal was prepared by the Exploring Coverage Alternatives Committee. While it has not received the same level of research and analysis as the first option, it could readily be analyzed with the support of appropriate industry experts. It would provide a more comprehensive benefits package for preventive, diagnostic and therapeutic services than the Flex Plan option, with the exception of hospitalization and catastrophic care.

#4—Medicaid Buy-In
This option provides the most comprehensive benefits package at the most effective and efficient cost, but is not available to many who do not meet immigration eligibility guidelines. This option was discussed at Executive Committee and full Task Force meetings. The committee addressing Coverage for the Working Uninsured presented information about past attempts to expand Medicaid coverage, but did not provide a comprehensive review of the current political environment.

This option would require a Section 1115 and/or a HIFA waiver. Contrary to prior rules, such waivers do not necessarily create an "entitlement" status for new recipients, and thus do not lock states into long-term funding commitments. It may be more feasible to obtain approval for this option if only adults with minor children are included, as is required under current Medicaid eligibility guidelines for those who meet the income requirements. If such a restriction is required, those without minor children could potentially be covered by other options, as could those who do not qualify due to immigration status guidelines. Furthermore, this option need not include any state funding and thus would be revenue neutral to the state.

Other Medicaid Buy-In options are in place or under review around the country. The careful review of these program experiences may bear further exploration.

#5—Medicaid/KidCare Coverage Options
The Task Force has also considered several Medicaid coverage options including:

- Expansion of Medicaid coverage to 100% of the Federal Poverty Level (FPL) for categorically eligible adults (currently set at 26% poverty). A waiver would not be required.

- Expansion of Medicaid coverage to unemployed adults up to 100% FPL. This would require a waiver.

- Preservation of the Medically Needy Program to provide coverage to categorically eligible adults with catastrophic health care expenses that will result in family poverty.

- Expansion of KidCare coverage to all children under 200% FPL regardless of immigration status. This would require state funding with possible local match.

- Expansion of Medicaid to pregnant women from 185% to 200% FPL.

Combined Options
All options are not mutually exclusive. In fact, the County may want to consider developing a combination of several options. Option #5 clearly exists separate and apart from the other options. Advantages may be reaped by combining options, such as seeking #4 Medicaid Buy-In in combination with any of the other options (1-3) in order to create a more seamless system that would allow for changes in patient circumstances and also cover those regardless of immigration status, presence of minor children, and even work status.

If a patient were initially insured through Option #1 or #3, and subsequently lost his/her job and coverage, s/he might be eligible for continuation of that coverage through Option # 2, TrustCare, thus better assuring provision of the "medical home" concept in which the providers have knowledge of the patient needs and coordinate care across the various providers. Option #4, Medicaid Buy-In, might also be offered through the PHT and JMH Health Plan, thus contributing to the continuity of options under the umbrella of a single plan.

Alternative Health Services Coordinating Boards

Another area where several options were considered was within the construct of an independent entity to provide the necessary planning and coordination to oversee and manage the implementation of the recommendations of the Task Force. Two options were initially considered: 1) expansion of the roles of the Public Health Trust by spinning off the Jackson Health System's governing board of directors as a separate

entity; or 2) retain the PHT in its governance role over the Jackson Health System and create a new autonomous organization.

After careful consideration the Task Force recommended the creation of a Health Care Coordinating Board with functions related to Planning, Allocations, Monitoring and Outcomes Analysis. Concurrently, some Task Force leadership members recognized the current model in place for benchmarking and planning activities within the sphere of social services that is under the rubric of the Alliance for Human Services. As such, an alternative name was proffered to create an "Alliance for Health Services." The primary role of such an alliance would be: "The Master Strategic Planning and Coordinating Organization for Health Services in Miami-Dade County."